SUMMARY OF BENEFITS

Connecticut General Life Insurance Co.

Maricopa County
Cigna Open Access Plus Copay/Coinsurance Plan

Annual deductibles and maximums	In-network	Out-of-network
Lifetime maximum	Unlimited per individual	
Pre-Existing Condition Limitation (PCL)	Applies	
Coinsurance	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met

Maximum Reimbursable Charge
• Determined based on the lesser of:
  • the health care professional's normal charge for a similar service; or
  • a percentage of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area.
• In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is determined based on the lesser of:
  • the health care professional's normal charge for a similar service or supply; or
  • the amount charged for that service by 80% of the health care professionals in the geographic area where it is received.
• Out-of-network services are subject to a contract year plan deductible and maximum reimbursable charge limitations.
	N/A	110%

Contract year plan deductible • The amount you pay for out-of-network services counts towards both your in-network and out-of-network plan deductibles. (One way accumulation) • After each family member meets his or her individual plan deductible, the plan will pay his or her claims, less any coinsurance amount. After the family plan deductible has been met, each individual's claims will be paid by the plan, less any coinsurance amount.	**Individual** $350 **Individual and family** $700	**Individual** $700 **Individual and family** $1,400
Contract year out-of-pocket maximum • The amount you pay for out-of-network services counts towards both your in-network and out-of-network out-of-pocket maximums. (One way accumulation)	**Individual** $2,000 **Individual and family** $4,000	**Individual** $4,000 **Individual and family** $8,000

Annual deductibles and maximums	In-network	Out-of-network
• Plan deductibles do not contribute toward the out-of-pocket maximum. • Benefit deductibles do not contribute towards the out-of-pocket maximum • Includes advanced radiological imaging copays. Other copays do not accumulate • Mental health and substance abuse services do not count towards your out-of-pocket maximum. • After each family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. After the family out-of-pocket maximum has been met, the plan will pay 100% of each individual's covered expenses.		

Benefits	In-network	Out-of-network
Physician services		
Office visit	**Primary care physician** You pay $40 per visit **CCN Specialist** You pay $55 per visit **Non-CCN Specialist** You pay $70 per visit	You pay 30% Plan pays 70% after the plan deductible is met
Convenience Care Visit	You pay $30 per visit	You pay 30% Plan pays 70% after the plan deductible is met
Allergy Treatment/Injections *Note: No charge after the per visit copay or the actual charge, whichever is less*	**Primary care physician** You pay $18 per visit **CCN Specialist** You pay $18 per visit **Non-CCN Specialist** You pay $33 per visit	You pay 30% Plan pays 70% after the plan deductible is met
Physician services (hospital) • In hospital visits and consultations • Inpatient • Outpatient	**Inpatient and outpatient services** You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met

Benefits	In-network	Out-of-network
Surgery (in a physician's office)	**Primary care physician** You pay $40 per visit **CCN Specialist** You pay $55 per visit **Non-CCN Specialist** You pay $70 per visit	You pay 30% Plan pays 70% per visit after the plan deductible is met
Preventive care		
Preventive care • Includes well-baby, well-child, well-woman and adult preventive care • Includes immunizations • Includes lab and x-ray billed by the doctor's office	No charge	Not covered
Mammogram, PSA, Pap Smear and Maternity Screening • Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.	No charge	You pay 30% Plan pays 70% after the plan deductible is met
Inpatient hospital facility services		
Semi-private room and board and other non-physician services • Inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc. • Private room stays may result in extra charges for the patient.	You pay 10% Plan pays 90% after the plan deductible is met *$1,000 Inpatient Maximum per admission*	You pay 30% Plan pays 70% after the plan deductible is met
Inpatient Professional Services • For services performed by surgeons and anesthesiologists	You pay 10% Plan pays 90% after the plan deductible is met *$1,000 Inpatient Maximum per admission*	You pay 30% Plan pays 70% after the plan deductible is met
Inpatient Professional Services • For services performed by radiologists, and pathologists	No charge	You pay 30% Plan pays 70% after the plan deductible is met
Multiple surgical reduction • Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.	Included	Included

Benefits	In-network	Out-of-network
Outpatient services		
Outpatient surgery (facility charges) • Non-surgical treatment procedures are not subject to the facility copay/benefit deductible.	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Outpatient Professional Services • For services performed by surgeons and anesthesiologists	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Outpatient Professional Services • For services performed by radiologists and pathologists	No charge	You pay 30% Plan pays 70% after the plan deductible is met
Physical, occupational, cognitive and speech therapy • 60 days per contract year for all therapies combined • Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy • Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short term rehab therapy maximum.	You pay $55 per visit	You pay 30% Plan pays 70% after the plan deductible is met
Cardiac rehabilitation • Limited to 36 days per contract year	You pay $55 per visit	You pay 30% Plan pays 70% after the plan deductible is met
Chiropractic care • Limited to 24 days per contract year	You pay $40 per visit	You pay 30% Plan pays 70% after the plan deductible is met
Lab and X-ray		
Lab and X-ray • Physician's office	No charge	You pay 30% Plan pays 70% after the plan deductible is met
Lab and X-ray • Outpatient hospital facility • Independent x-ray and/or lab facility	No charge	You pay 30% Plan pays 70% after the plan deductible is met

Benefits	In-network	Out-of-network
Lab and X-ray, emergency room and urgent care • Emergency room when billed by the facility as part of the emergency room visit • Urgent care when billed by the facility as part of the urgent care visit. • Independent x-ray and/or lab facility in conjunction with a emergency room visit	No charge	
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) • Physician's office visit	You pay a per scan copay of $100, then no charge	You pay 30% Plan pays 70% after the plan deductible is met
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) • Inpatient hospital facility	You pay 10% Plan pays 90% after the plan deductible is met *$1,000 Inpatient Maximum per admission*	You pay 30% Plan pays 70% after the plan deductible is met
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) • Outpatient facility	You pay a per scan copay of $100, after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) • Emergency room • Urgent care facility	You pay a per scan copay of $100, then no charge	
Emergency and urgent care services		
Hospital emergency room • Includes radiology, pathology and physician charges • Copay waived if admitted, then inpatient hospital charges would apply • Out-of-network services are covered at the in-network rate.	You pay a $200 copay, then no charge	
Ambulance • Out-of-network services are covered the same as in-network services. Note: Non-emergency transportation (e.g. from hospital back home) is generally not covered.	You pay 10% Plan pays 90% after the in-network plan deductible is met	
Urgent care services • Out-of-network services are covered at the in-network rate. • Copay waived if admitted, then inpatient hospital charges would apply.	You pay a $75 copay, then no charge	

Benefits	In-network	Out-of-network
Other health care facilities		
Skilled nursing facility, rehabilitation hospital and other facilities • 90 days per contract year	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Home health care • Unlimited days per contract year	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Hospice Inpatient services Outpatient services	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Other health care services		
Durable medical equipment • Unlimited contract year maximum	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
External prosthetic appliances (EPA) • Unlimited contract year maximum	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met

Benefits	In-network	Out-of-network
Bariatric Surgery • Treatment of clinically severe obesity, as defined by the body mass index (BMI) • Waiting Period: One year from date of initial Employment (to be verified by Maricopa County) **Physician's Services/Office Visit** **Inpatient Hospital** **Inpatient Professional Services** ***$1000 out of pocket maximum per admission*** **Outpatient Facility Services** **Outpatient Professional Services** *The following are excluded:* *Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision*	You pay $500 Bariatric Copay, then: No charge after the PCP or applicable CCN or Non-CCN Specialist per office visit copay You pay 10% Plan pays 90% after the plan deductible is met	Not Covered
TMJ, surgical and non-surgical	Not covered	Not covered

Benefits	In-network	Out-of-network
Maternity care services • Covers maternity for employee and all dependents. **Initial Visit to Confirm Pregnancy** **All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges (i.e. global maternity fee)** **Office Visits in addition to the global maternity fee when performed by an OB or Specialist** **Delivery – Facility (Inpatient Hospital, Birthing Center)**	No charge after the PCP or applicable CCN or Non-CCN Specialist per office visit copay You pay 10% Plan pays 90% after the plan deductible is met No charge after the PCP or applicable CCN or Non-CCN Specialist per office visit copay You pay 10% Plan pays 90% after the plan deductible is met ***$1000 out of pocket maximum per admission*	You pay 30% Plan pays 70% after the plan deductible is met
Infertility **Office visit for testing, treatment and artificial insemination** **Inpatient hospital facility** ***$1000 out of pocket maximum per admission*** **Outpatient hospital facility** **Physician services** **Surgical treatment limited to procedures to correct infertility, excluding In-vitro, GIFT, ZIFT, etc.**	No charge after the PCP or applicable CCN or Non-CCN Specialist per office visit copay You pay 10% Plan pays 90% after the plan deductible is met	Not covered

Benefits	In-network	Out-of-network
Family planning • Surgical services such as tubal ligation or vasectomy are covered (excluding reversals). • Includes contraceptive devices **Office Visit** **Inpatient hospital facility** **Outpatient facility**	No charge aftter the PCP or applicable CCN or Non-CCN Specialist per office visit copay You pay 10% Plan pays 90% after the plan deductible is met ***$1000 out of pocket maximum per admission ***	You pay 30% Plan pays 70% after the plan deductible is met
Hearing services and Hearing Aids *Separate $2,000 Hearing Aid Maximum per ear per member every three years* *All providers covered*	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Alternative Medical Services • Acupuncture/Acupressure • Biofeedback • Naturopathic • Other specific Approved Services Provided by a designated Alternative Medicine Provider • 20 visits per contract year • No prior authorization required	No charge after $40 per visit copay	Not Covered
Homeopathic/Herbal Medical Products • Herbal and homeopathic products which are approved by the HEALTHPLAN are covered at no charge when obtained at the Designated Alternative Medicine Center • Contract year Maximum of $60	No charge	Not covered
Mental health and substance abuse services		
Mental Health and Substance Abuse	Carved out to Magellan	
Prescription drugs		
Pharmacy coverage	Carved out to Catalyst Rx	
Vision care	Carved out to EyeMed	

Definitions

Coinsurance – After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called coinsurance.

Copay – A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

Cost and reimbursement vary based upon place of service – Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

Deductible – A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

Direct Access to Obstetricians and Gynecologists – You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card.

Out-of-pocket Maximum – Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "maximum reimbursable charges" or negotiated fees for covered services.

Pre-existing condition limitation – Not applicable to anyone under 19 years old. Applies to any injury or sickness that you are diagnosed with and receive treatment for, or incur expenses for during the 90 days before you are insured by these benefits or you begin an eligibility waiting period (whichever is earlier). Please refer to your plan documents for specific details.

Selection of a Primary Care Provider – Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

Transition of Care – Provides in-network health coverage to new customers when the customer's doctor or facility is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor and/or remain in the same facility.

Maximizing your health care dollars

Log on to myCigna.com for resources to help you choose a health care professional or compare the cost and quality of medical services, medications and hospital care.

When you need a medical service or procedure, Cigna offers you opportunities to save on prescription medicine, routine medical care, laboratory services, radiology scans, and outpatient surgery. Details are below:

Lab – Save on lab services by using a free-standing laboratory instead of a hospital- or clinic-based lab.

Urgent Care – For non-emergency conditions that need attention before you can see your doctor, you can save money by going to an urgent care center instead of an Emergency Room (ER).

Convenience Care – For minor or routine conditions, go to a Convenience Care Clinic when your doctor is unavailable. Convenience Care Clinics are retail-based and often found in pharmacies or grocery stores.

Radiology – Costs for MRIs, PET, and CT scans can vary greatly. Non-hospital based outpatient radiology centers often cost much less than a hospital. Cigna's network includes both hospitals and outpatient centers, so you can find a radiology center that's right for you.

Outpatient Surgery – Costs for colonoscopies, arthroscopies, and other outpatient procedures can vary greatly. Using a free-standing outpatient surgery center can save hundreds of dollars.

Exclusions

What's Not Covered (*not all-inclusive*):

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Services provided through government programs
- Services that aren't medically necessary
- Experimental, investigational or unproven services
- Services for an injury or illness that occurs while working for pay or profit including services covered by worker's compensation benefits
- Cosmetic services
- Dental care, unless due to accidental injury to sound natural teeth
- Reversal of sterilization procedures
- Genetic screenings
- Non-prescription and anti-obesity drugs
- Custodial and other non-skilled services
- Weight loss programs
- Treatment of TMJ Disorder
- Treatment of sexual dysfunction
- Travel immunizations
- Eyeglass lenses and frames, contact lenses and surgical vision correction

These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

Behavioral Health, Inc., Tel-Drug, Inc., Tel-Drug of Pennsylvania, L.L.C. and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. In Arizona, HMO plans are offered by Cigna HealthCare of Arizona, Inc. In Connecticut, HMO plans are offered by Cigna HealthCare of Connecticut, Inc. In North Carolina, HMO plans are offered by Cigna HealthCare of North Carolina, Inc. In California, HMO and Network plans are offered by Cigna HealthCare of California, Inc. All other medical plans in these states are insured or administered by CGLIC or CHLIC. "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C.